DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 5 — 2 4

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 1995

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(a)(13)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 1994-1995 $ 8.2m
b. FFY 1995-1996 $ 1.2m

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D Part I Pages 33(a),47(x)(4), 47(x)(5),47(x)(6),47(x)(7),47(x)(8),47(x)(9), 47(x)(10),51(a),110(E) Appendix

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D Part I Pages 51(a), 110(E) Appendix

No Previous Pages 33(a),47(x)(4) - 47(x)(10)

10. SUBJECT OF AMENDMENT:
Long Term Care Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Brian J. Wing

14. TITLE:
Acting Commissioner

15. DATE SUBMITTED:
June 30, 1995

16. RETURN TO:
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243

17. [redacted]

21. TYPED NAME:
Sue Kelly

23. REMARKS:
47(x)(5), [redacted] also being approved as per same State letter [redacted] pages 33(a), [redacted], 47(x)(9), 47(x)(10) and 51(a). As per State letter dated 05/22/[redacted] 4.19-B Page 1(c) and 47(x)(4) are being include and approved.

FORM HCFA-179 (07-92)

Instructions on Back

New York
33 (a)

86-2.10 (6/95)
Attachment 4.19D
Part I

For purposes of establishing the indirect component of the rate of payment for services provided on or after April 1, 1995, the reimbursable base year costs as reported in the fiscal services and administrative services functional cost centers, as specified in subparagraphs (i) and (ii) of this paragraph, of a provider of services, excluding a provider of services reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and fiscal service costs. For the purposes of this paragraph, reimbursable base year* administrative and fiscal services costs shall mean those base year administrative and fiscal services costs remaining after application of all other efficiency standards, including but not limited to, peer group ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses provided by this paragraph shall be expressed as a percentage reduction of the operating cost component of the rate promulgated for each residential health care facility.

*For most facilities, the base year is 1983, however, new facilities or facilities that changed ownership will be on a more current base year which reflects the date of new ownership or the change in ownership.

TN 95-24 Approval Date JUN 06 2001
Supersedes TN New Effective Date APR 01 1995

86-2.10 (6/95)
Attachment 4.19-D
Part I

(x) Residential health care facility rates of payment for services provided on or after July 1, 1995 shall be reduced by the Commissioner, to reflect the elimination of operational requirements previously mandated by law or regulation or the Commissioner or other governmental agency, by a factor determined as follows:

(i) an aggregate reduction shall be calculated for each residential health care facility as the result of (a) fifty-six million dollars on an annualized basis for 1995, trended to the rate year by the trend factor for projection of reimbursable costs to the rate year, multiplied by (b) the ratio of patient days for patients eligible for payments made by governmental agencies provided in a base year two years prior to the rate year by a residential health care facility, divided by the total of such patient days summed for all residential health care facilities; and

(ii) the result for each residential health care facility shall be divided by such patient days for patients eligible for payment made by governmental agencies provided in the residential health care facility, for a per diem reduction in rates of payment for such residential health care facility for patients eligible for payments made by governmental agencies.

TN 95-24 1 Approval Date JUN 06 2001
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Medicare Utilization. (1) Prior to February 1, 1996, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to Medicare beneficiaries, divided by the sum of such days of care plus days of care provided to residents eligible for Medicaid payments, expressed as a percentage, for the period commencing July 1, 1995 to the last date for which such data is available and reasonably accurate. This value shall be called the statewide target percentage.

(2) Prior to February 1, 1996, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to Medicare beneficiaries, divided by the sum of such days of care plus days of care provided to residents eligible for Medicaid payments, expressed as a percentage, for the period April 1, 1994 through March 31, 1995. This value shall be called the statewide base percentage.

(3) If the statewide target percentage is not at least one percentage point higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the statewide target percentage is not at

least one percentage point higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the statewide reduction percentage. If the statewide target percentage is at least one percentage point higher than the statewide base percentage, the statewide reduction percentage shall be zero.

(4) The statewide reduction percentage shall be multiplied by thirty-four million dollars to determine the statewide aggregate reduction amount. If the statewide reduction percentage shall be zero, there shall be no reduction amount.

(5) The statewide aggregate reduction amount shall be allocated by the commissioner of health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for Medicaid payments on the basis of the extent of each facility's failure to achieve a one percentage point increase in the target percentage compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a one percentage point increase in the target percentage compared to the base percentage. This amount shall be called the facility

specific reduction amount.

(6) The facility specific reduction amount shall be due to the state from each residential health care facility and may be recouped by the state in a lump sum amount or amounts from Medicaid payments due to the residential health care facility.

(7) On or about June 1, 1996, the commissioner of health shall calculate for the period July 1, 1995 through March 31, 1996 a statewide target percentage, a statewide reduction percentage, a statewide aggregate reduction amount, and a facility specific reduction amount in accordance with the methodology provided in paragraphs 1, 3,4, and 5 of this provision. The facility specific reduction amount calculated in accordance with this paragraph shall be compared to the facility specific reduction amount calculated in accordance with paragraph 5 of this provision. Any amount in excess of the amount determined in accordance with paragraph 5 of this provision shall be due to the state from each residential health care facility and may be recouped in the same manner as specified in paragraph 6 of this provision. If the amount is less than the

amount determined in accordance with paragraph 5 of this provision, the difference shall be refunded to the residential health care facility by the state no later than July 15, 1996. Residential health care facilities shall submit utilization data for the period July 1, 1995 through March 31, 1996 to the commissioner of health by April 15, 1996.

(f)(1) On or about September first of each year, the consultants shall provide to the Commissioner and the State Hospital Review and Planning Council, the methodology to be used to determine the trend factors for the rate period, commencing on the next January first. The Commissioner shall monitor the actual price movements during these periods of the external price indicators used in the methodology, shall report the results of the monitoring to the consultants and shall implement the recommendations of the consultants for one prospective interim annual adjustment to the initial trend factors to reflect such price movements and to be effective on January first, one year after the initial trend factors were established and one prospective final annual adjustment to the revised trend factors to reflect such price movements and to be effective on January first, two years after the initial trend factors were established.

(2) Notwithstanding the dates specified in paragraph (1), the consultants shall provide as soon as possible to the Commissioner and the State Hospital Review and Planning Council, the methodology to be used to determine the trend factor for the rate period April 1, 1991 to December 31, 1991. One prospective interim annual adjustment for this rate period shall be made on January 1, 1992 and one prospective final annual adjustment for this rate period shall be made January 1, 1993.

(g) For reimbursement of services provided to patients for the period April 1, 1995 through December 31, 1995, the trend factors established in accordance with subdivisions (d),(e) and (f) of this section shall reflect no trend factor projections applicable to the period January 1, 1995 through December 31, 1995 and no trend factor adjustments applicable to periods prior to January 1, 1995 other than those reflected in 1994 rates of payment and provided further, that this subdivision shall not apply to use of the trend factor for the January 1, 1995 through December 31, 1995 period, any interim adjustment to the trend factor for such period, or the final trend factor for such period for purposes of projection of allowable operating costs to subsequent rate periods. The Commissioner of Health shall adjust such rates of payment to reflect the exclusion of trend factor projections pursuant to this subdivision.

medical supplies, administrative overhead, general and capital costs. The rates are regionally adjusted to reflect differences in labor costs for personnel providing direct patient care and clinic support staff. The rates have been set prospectively by applying an economic trend factor.

For services provided on or after April 1, 1995 by providers designated as preferred primary care providers, rates of payment may be established pursuant to the reimbursement payment methodology described in this section only for services provided by providers which submitted bills prior to December 31, 1994 based on the reimbursement payment methodology described in this section, or by a general hospital designated as a financially distressed hospital, which applied on or before April 1, 1995 for designation as a preferred primary care provider. The reimbursement methodology described in this section is an alternative to the prospective average cost per visit reimbursement method used for non-participating hospitals. There are unique features present in the reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the financial responsibility of providers for selected laboratory and other ancillary procedures and Medicaid revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.

Ordered Ambulatory Services (specific services performed by a [freestanding clinic] <u>hospital</u> on an ambulatory basis upon the order of a qualified physician, physician's assistant, dentist or podiatrist to test, diagnose or treat a recipient or specimen taken from a recipient)

Fee schedule developed by the Department of Health and approved by the Division of the Budget for each type of service, as appropriate.

Payment for these services will not exceed the combined

New York
33 (a)

86-2.10 (6/95)
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(2) Prior to February 1, 1996, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to Medicare beneficiaries, divided by the sum of such days of care plus days of care provided to residents eligible for Medicaid payments, expressed as a percentage, for the period April 1, 1994 through March 31, 1995. This value shall be called the statewide base percentage.

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